		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041491

Facility Name: City Care Center of Cobden

Address: 430 S. Front Street (Number) Cobden (City) 62920 (Zip Code)

County: Union

Telephone Number: 618-893-4214 **Fax #** ( )

IDPA ID Number: 36-4017931

Date of Initial License for Current Owners: 12/01/95

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[X]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Mendel S Schneider **Telephone Number:** 847-933-1274

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) See Accountant's Report Attached (Date)
(Print Name and Title) _____
(Firm Name & Address) Mendel S. Schneider & Associates, CPA, PC.
4556 Oakton St., Ste 200, Skokie, Il. 60076
(Telephone) 847-933-1274 Fax # 847-933-1283

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number City Care Center of Cobden # 0041491 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	16	Skilled (SNF)	16	5,856	1
2		Skilled Pediatric (SNF/PED)			2
3	58	Intermediate (ICF)	58	21,228	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	74	TOTALS	74	27,084	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,830	130	516	2,476	8
9	SNF/PED					9
10	ICF	16,438	2,398	1,587	20,423	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,268	2,528	2,103	22,899	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.55%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/01/95

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/01/95 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 10 and days of care provided 516

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/ Fiscal Year: 12/31

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number City Care Center of Cobden # 0041491 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	92,807	8,986	3,217	105,010		105,010		105,010			1
2	Food Purchase		97,824		97,824	(4,000)	93,824	(315)	93,509			2
3	Housekeeping	103,723	11,711	2,966	118,400		118,400		118,400			3
4	Laundry		18,177		18,177		18,177		18,177			4
5	Heat and Other Utilities			46,463	46,463		46,463	934	47,397			5
6	Maintenance	23,058		18,034	41,092		41,092	1,324	42,416			6
7	Other (specify):*											7
8	**TOTAL General Services**	219,588	136,698	70,680	426,966	(4,000)	422,966	1,943	424,909			8
	B. Health Care and Programs											
9	Medical Director			3,700	3,700		3,700		3,700			9
10	Nursing and Medical Records	492,711	58,857	1,520	553,088		553,088		553,088			10
10a	Therapy											10a
11	Activities	16,304	252		16,556		16,556		16,556			11
12	Social Services	20,623			20,623		20,623		20,623			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	529,638	59,109	5,220	593,967		593,967		593,967			16
	C. General Administration											
17	Administrative	55,983			55,983		55,983	27,461	83,444			17
18	Directors Fees											18
19	Professional Services			70,678	70,678		70,678	(54,850)	15,828			19
20	Dues, Fees, Subscriptions & Promotions			4,076	4,076	838	4,914	(1,873)	3,041			20
21	Clerical & General Office Expenses	31,972	14,008	11,694	57,674		57,674	37,240	94,914			21
22	Employee Benefits & Payroll Taxes			130,300	130,300	3,162	133,462	12,561	146,023			22
23	Inservice Training & Education											23
24	Travel and Seminar			480	480		480		480			24
25	Other Admin. Staff Transportation							3,620	3,620			25
26	Insurance-Prop.Liab.Malpractice			73,473	73,473		73,473	893	74,366			26
27	Other (specify):*											27
28	**TOTAL General Administration**	87,955	14,008	290,701	392,664	4,000	396,664	25,052	421,716			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	837,181	209,815	366,601	1,413,597		1,413,597	26,995	1,440,592			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number City Care Center of Cobden #0041491 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			6,429	6,429		6,429	19,652	26,081			30
31	Amortization of Pre-Op. & Org.							29,172	29,172			31
32	Interest			10,890	10,890		10,890	171,191	182,081			32
33	Real Estate Taxes							22,165	22,165			33
34	Rent-Facility & Grounds			279,000	279,000		279,000	(272,301)	6,699			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			296,319	296,319		296,319	(30,121)	266,198			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			40,626	40,626		40,626		40,626			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			40,626	40,626		40,626		40,626			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	837,181	209,815	703,546	1,750,542		1,750,542	(3,126)	1,747,416			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number City Care Center of Cobden # 0041491 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	7,500	30		9
10	Interest and Other Investment Income	(584)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(315)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,000)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,873)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule ABS Management	(54,197)	19		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (51,469)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(43,259)		34
35	Other- Attach Schedule **Allocate Indirect Cost**	91,602		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 48,343		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (3,126)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

City Care Center of Cobden

ID# 0041491

Report Period Beginning: 01/01/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number City Care Center of Cobden **#** 0041491 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(315)	0	0	0	0	0	0	0	0	0	0	(315)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(315)	0	0	0	0	0	0	0	0	0	0	(315)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,000)	0	0	0	0	0	0	0	0	0	0	(2,000)	19
20	Fees, Subscriptions & Promotions	(1,873)	0	0	0	0	0	0	0	0	0	0	(1,873)	20
21	Clerical & General Office Expenses	0	477	0	0	0	0	0	0	0	0	0	477	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(3,873)	477	0	0	0	0	0	0	0	0	0	(3,396)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(4,188)	477	0	0	0	0	0	0	0	0	0	(3,711)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number City Care Center of Cobden # 0041491 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	7,500	12,152	0	0	0	0	0	0	0	0	0	19,652	30
31	Amortization of Pre-Op. & Org.	0	29,172	0	0	0	0	0	0	0	0	0	29,172	31
32	Interest	(584)	171,775	0	0	0	0	0	0	0	0	0	171,191	32
33	Real Estate Taxes	0	22,165	0	0	0	0	0	0	0	0	0	22,165	33
34	Rent-Facility & Grounds	0	(279,000)	0	0	0	0	0	0	0	0	0	(279,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	6,916	(43,736)	0	0	0	0	0	0	0	0	0	(36,820)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,728	(43,259)	0	0	0	0	0	0	0	0	0	(40,531)	45

Facility Name & ID Number City Care Center of Cobden # 0041491 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Schedule Attached		See Schedule Attached		Cobden, LLC	Cobden	Bldg Rental
				ABS Management	Chicago	Management

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 279,000	The Willow of Cobden, LLC.	100.00%	$	$ (279,000)	1
2	V	33	Real Estate Tax		The Willow of Cobden, LLC.		22,165	22,165	2
3	V	32	Interest		The Willow of Cobden, LLC.		171,775	171,775	3
4	V	30	Depreciation		The Willow of Cobden, LLC.		12,152	12,152	4
5	V	31	Amortization		The Willow of Cobden, LLC.		29,172	29,172	5
6	V	21	Office		The Willow of Cobden, LLC.		477	477	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 279,000			$ 235,741	$ * (43,259)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number City Care Center of Cobden # 0041491 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Sam Brandman		Administrative	11.00	29,786	2.36	4.75	ABS Salary	$ 4,214	17-7	1
2	David Abell		Administrative	11.00	61,323	5.25	10.50	ABS Salary	8,677	17-7	2
3	Tamar Abell		Administrative	11.00	35,042	3.75	7.50	ABS Salary	4,958	17-7	3
4	Joseph Brandman		Administrative	22.00	67,932	4.25	8.75	ABS Salary	9,612	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 27,461		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number City Care Center of Cobden # 0041491 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: ABS Management
Street Address: 2711 W. Howard
City / State / Zip Code: Chicago, Il. 60645
Phone Number: (773-338-4400
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Sam Brandman		597		$ 34,000	$ 34,000	74	$ 4,214	1
2	17	David Abell		597		70,000	70,000	74	8,677	2
3	17	Tamar Abell		597		40,000	40,000	74	4,958	3
4	17	Joseph Brandman		597		77,544	77,544	74	9,612	4
5	21	Clerical		597		200,303	200,303	74	24,828	5
6	6	Repairs & Maintenance		597		10,683		74	1,324	6
7	34	Rent		597		54,045		74	6,699	7
8	22	Health & Welfare		597		65,809		74	8,157	8
9	26	Insurance		597		7,207		74	893	9
10	21	Office		597		96,286		74	11,935	10
11	19	Professional Fees		597		10,871		74	1,347	11
12	22	Payroll Taxes		597		35,533		74	4,404	12
13	5	Utilities		597		7,533		74	934	13
14	25	Auto & Travel		597		29,205		74	3,620	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 739,019	$ 421,847		$ 91,602	25

Facility Name & ID Number City Care Center of Cobden # 0041491 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	American National Bank		X	Mortgage	$21,444.90	07/24/98	$ 2,600,000	$ 2,153,258	07/24/08	7.6800	$ 171,775	1
2												2
3												3
4												4
5												5
	Working Capital											
6	American National Bank		X	Working Capital			200,000	249,842		5.0000	10,890	6
7												7
8												8
9	TOTAL Facility Related				$21,444.90		$ 2,800,000	$ 2,403,100			$ 182,665	9
	B. Non-Facility Related*											
10	Interest Income										(584)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (584)	14
15	TOTALS (line 9+line14)						$ 2,800,000	$ 2,403,100			$ 182,081	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number City Care Center of Cobden # 0041491 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	22,208	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	21,967	2
3. Under or (over) accrual (line 2 minus line 1).	$	(241)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	22,406	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	22,165	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	18,031	8
	2000	21,591	9
	2001	21,915	10
	2002	21,773	11
	2003	21,967	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

Line 4: 21967 x 1.02

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME City Care Center of Cobden COUNTY Union

FACILITY IDPH LICENSE NUMBER 0041491

CONTACT PERSON REGARDING THIS REPORT David Abell

TELEPHONE 773-338-4400 FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-31-02-784-C		$ 21,966.64	$ 21,966.64
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 21,966.64	$ 21,966.64

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number City Care Center of Cobden # 0041491 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 455,180
2. Number of Years Over Which it is Being Amortized: 15
3. Current Period Amortization: 29,172
4. Dates Incurred: 12/01/95

Nature of Costs: Goodwill, Mortgage Costs
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1995	$ 15,000	1
2					2
3	TOTALS			$ 15,000	3

Facility Name & ID Number City Care Center of Cobden # 0041491 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	74		1995		$ 475,200	$ 12,152	39	$ 12,152	$	$ 109,368	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Generator			1998	10,130	260	39	260		1,614	9
10	Remodeling-Addition of Dining Room & Rec Room										10
11	Site Preparation			1999	60,320	1,547	39	1,547		8,057	11
12	Concrete, Masonery, Drywall			1999	50,469	1,294	39	1,294		6,740	12
13	Carpentry			1999	25,069	643	39	643		3,349	13
14	Electrical			1999	20,340	522	39	522		2,719	14
15	Heating, Ventilation & Air Conditioning			1999	9,693	249	39	249		1,297	15
16	Plumbing			1999	11,326	290	39	290		1,510	16
17	Flooring			1999	2,280	58	39	58		302	17
18	Painting			1999	4,100	105	39	105		547	18
19	Sprinkler System			1999	13,100	336	39	336		1,750	19
20	Doors & Hardware			1999	8,886	228	39	228		1,187	20
21	Aluminum Railing			1999	11,630	298	39	298		1,552	21
22	Tiling			2002	11,378	292	39	292		803	22
23	Remodeling-Halls			2003	11,945	307	39	307		460	23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number City Care Center of Cobden # 0041491 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 725,866	$ 18,581		$ 18,581	$	$ 141,255	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number City Care Center of Cobden # 0041491 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 75,000	$	$ 7,500	$ 7,500	10	$ 67,500	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 75,000	$	$ 7,500	$ 7,500		$ 67,500	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	Van	1998	$ 5,976	$	$	$	5	$ 5,976	76
77										77
78										78
79										79
80	TOTALS			$ 5,976	$	$	$		$ 5,976	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 821,842	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 18,581	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 26,081	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 7,500	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 214,731	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number City Care Center of Cobden # 0041491 Report Period Beginning: 01/01/04 Ending: 12/31/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocated from ABS Management				6,699			5
6								6
7	TOTAL				$ 6,699 **			7

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number City Care Center of Cobden # 0041491 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number City Care Center of Cobden **#** 0041491 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/04 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 11,994	$ (4,047)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	456,634	456,634	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	39,029	39,029	6
7	Other Prepaid Expenses	110,050	110,050	7
8	Accounts Receivable (owners or related parties)	1,000		8
9	Other(specify): Due from Others	369,956	1,377,956	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 988,663	$ 1,979,622	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		15,000	13
14	Buildings, at Historical Cost		475,200	14
15	Leasehold Improvements, at Historical Cost	250,666	250,666	15
16	Equipment, at Historical Cost	5,976	80,976	16
17	Accumulated Depreciation (book methods)	(37,863)	(224,017)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		437,580	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(257,878)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 218,779	$ 777,527	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,207,442	$ 2,757,149	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 164,309	$ 164,309	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	249,842	249,842	29
30	Accrued Salaries Payable	48,852	48,852	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,640	4,640	31
32	Accrued Real Estate Taxes(Sch.IX-B)		22,406	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 467,643	$ 490,049	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,153,258	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 2,153,258	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 467,643	$ 2,643,307	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 739,799	$ 113,842	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,207,442	$ 2,757,149	48

***(See instructions.)**

Facility Name & ID Number City Care Center of Cobden # 0041491 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 689,023	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 689,023	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	50,776	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 50,776	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 739,799	24	*

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,803,836	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,803,836	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	584	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 584	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,804,420	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	426,966	31
32	Health Care	593,967	32
33	General Administration	392,664	33
	B. Capital Expense		
34	Ownership	296,319	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	40,626	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,750,542	40
41	**Income before Income Taxes (line 30 minus line 40)****	53,878	41
42	**Income Taxes**	(3,102)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 50,776	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,444	1,580	$ 27,197	$ 17.21	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,959	1,991	31,524	15.83	3
4	Licensed Practical Nurses	10,350	12,020	141,485	11.77	4
5	Nurse Aides & Orderlies	39,483	41,767	292,505	7.00	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,630	2,783	16,304	5.86	10
11	Social Service Workers	2,032	2,280	20,623	9.05	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	20,053	9.64	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,531	12,247	72,754	5.94	15
16	Dishwashers					16
17	Maintenance Workers	2,080	2,080	23,058	11.09	17
18	Housekeepers	17,508	18,224	103,723	5.69	18
19	Laundry					19
20	Administrator	2,408	2,631	55,983	21.28	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,040	2,120	31,972	15.08	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	95,545	101,803	$ 837,181 *	$ 8.22	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	70	$ 3,217	1-3	35
36	Medical Director	60	3,700	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	37	1,520	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	167	$ 8,437		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Terri Hickman	Administrator	0	$ 55,983
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 55,983

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Mendel S Schneider	Accounting	$ 8,300
Richard Peelo	Accounting	3,850
ABS Management	Home Office-Adjusted Out	54,197
Personnel Planners	UC Tax Consultant	961
Meyer Magence	Legal	200
Sachnoff & Weaver	Legal	1,170
Sachnoff & Weaver	Legal-Adjusted Out	2,000
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 70,678

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 44,609
Unemployment Compensation Insurance	8,973
FICA Taxes	66,902
Employee Health Insurance	21,539
Employee Meals	4,000
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$ 146,023

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	838
Health Care Worker Background Check	
(Indicate # of checks performed)	
Advertising	1,873
Southern Illinoisian-Subs	213
Less: Public Relations Expense	( )
Non-allowable advertising	(1,873)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,041

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Ill Health Care	120
ICLTC	360
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 480

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number City Care Center of Cobden # 0041491 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number City Care Center of Cobden **#** 0041491 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **N/A**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **4,500** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **40,626**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **4,000** Has any meal income been offset against related costs? **No** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **No**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.